

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6209

CERTIFICATE OF DEATH

06190

Reg. Dist. No. 90

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick				c. LENGTH OF STAY IN 1b 5-4 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Walter Winslow Abkin				4. DATE OF DEATH Month 6/19/1957 Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/13/1902 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State of foreign country) Ind.	
13. FATHER'S NAME Harry L. Abkin				14. MOTHER'S MAIDEN NAME Agnes Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. 217-12-8248		17. INFORMANT Edna Moore Middletown Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 VENTRICULAR FIBRILLATION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MASSIVE MYOCARDIAL INFARCTION (c) CORONARY OCCLUSION				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous Coronary Artery Disease				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Syncope			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 1956, to 6/19/1957, that I last saw the deceased alive on 6/19/1957, and that death occurred at 9 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Wallace Oberstain				ADDRESS (Street, city or town, state) Cecilton, Md			
DATE SIGNED 21 June 57							
PHYSICIAN'S NAME (Type) Wallace Oberstain							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6/22/57		22c. NAME OF CEMETERY OR CREMATORY Warwick		22d. LOCATION (City, town, or county) (State) Warwick Ind.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Lister Daniels				ADDRESS Middletown Del.		24a. REC'D BY REGISTRAR DATE 6/21/57	
						24b. REGISTRAR'S SIGNATURE Mrs. Ralph A. Kears	

CERTIFICATE OF DEATH

500

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1915</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1957</u></p>		<p>6. Place of death: <u>HOME</u></p>	
<p>7. Cause of death: <u>HEART DISEASE</u></p>		<p>8. Manner of death: <u>NATURAL</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1957</u></p>		<p>12. Place of registration: <u>BALTIMORE</u></p>	

BUREAU V. S.

JUN 25 1957

RECEIVED

6210

CERTIFICATE OF DEATH

06191

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. LENGTH OF STAY IN lb 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Anderson Last Anderson		4. DATE OF DEATH Month June Day 30 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1872
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 3 Days 5 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daniel Howllway		14. MOTHER'S MAIDEN NAME Francis Billings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Morris Anderson		Address Perryville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Sclerosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-Sclerosis DUE TO (c) Myocarditis			INTERVAL BETWEEN ONSET AND DEATH 3 months 5 yrs. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 334X			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 25 - 1956 to June 29, 1957 , that I last saw the deceased alive on June 29, 1957 , and that death occurred at 2:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence H. Benson M.D.		ADDRESS (Street, city or town, state) Fort Belvoir, Md.	
PHYSICIAN'S NAME (Type) CLARENCE H. BENSON		DATE SIGNED 11/1/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 3 1957	22c. NAME OF CEMETERY OR CREMATORY Brookview Cem.	22d. LOCATION (City, town, or county) (State) Rising Sun Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson		ADDRESS Rising Sun, Md.	
24a. REC'D BY REGISTRAR June Daugherty		24b. REGISTRAR'S SIGNATURE June Daugherty	

MEDICAL CERTIFICATION

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1957 2

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6211

CERTIFICATE OF DEATH

06192

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS Bush Chapel Road	
3. NAME OF DECEASED First ALFRED Middle (NMI) Last BATTLE		4. DATE OF DEATH Month June Day 13 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-1-95
9. AGE (In years lost birthday) yrs. 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Battle		14. MOTHER'S MAIDEN NAME Sophie (?)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, uremic poisoning 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic glomerulonephritis DUE TO (c) Arteriosclerosis, general, severe 450.0		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. VA 19 57		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 16 , 19 57 , to June 13 , 19 57 , and that death occurred at 3:55 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		DATE SIGNED 6-13-57	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 6-16-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Aberdeen, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tarring Funeral Home, Aberdeen, Md.		24a. REC'D BY REGISTRAR June 17-57	
24b. REGISTRAR'S SIGNATURE Hellie G. Perry		24c. REGISTRAR'S SIGNATURE Helen Dougherty	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth	
6. Date of death		7. Time of death		8. Place of death		9. Cause of death		10. Manner of death	
11. Signature of physician		12. Signature of registrar		13. Signature of informant		14. Signature of witness		15. Signature of funeral director	
16. Name of funeral home		17. Address of funeral home		18. City and State of funeral home		19. Date of funeral		20. Time of funeral	
21. Name of cemetery		22. Address of cemetery		23. City and State of cemetery		24. Date of burial		25. Time of burial	
26. Name of undertaker		27. Address of undertaker		28. City and State of undertaker		29. Date of service		30. Time of service	
31. Name of family		32. Address of family		33. City and State of family		34. Date of service		35. Time of service	
36. Name of church		37. Address of church		38. City and State of church		39. Date of service		40. Time of service	
41. Name of pastor		42. Address of pastor		43. City and State of pastor		44. Date of service		45. Time of service	
46. Name of sexton		47. Address of sexton		48. City and State of sexton		49. Date of service		50. Time of service	
51. Name of organist		52. Address of organist		53. City and State of organist		54. Date of service		55. Time of service	
56. Name of soloist		57. Address of soloist		58. City and State of soloist		59. Date of service		60. Time of service	
61. Name of choir		62. Address of choir		63. City and State of choir		64. Date of service		65. Time of service	
66. Name of band		67. Address of band		68. City and State of band		69. Date of service		70. Time of service	
71. Name of orchestra		72. Address of orchestra		73. City and State of orchestra		74. Date of service		75. Time of service	
76. Name of soloists		77. Address of soloists		78. City and State of soloists		79. Date of service		80. Time of service	
81. Name of chorus		82. Address of chorus		83. City and State of chorus		84. Date of service		85. Time of service	
86. Name of orchestra		87. Address of orchestra		88. City and State of orchestra		89. Date of service		90. Time of service	
91. Name of soloists		92. Address of soloists		93. City and State of soloists		94. Date of service		95. Time of service	
96. Name of chorus		97. Address of chorus		98. City and State of chorus		99. Date of service		100. Time of service	

BUREAU V. S.

JUN. 19 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06193

6212

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS Aiken Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WALTER L. BEAUCHAMP		4. DATE OF DEATH Month Day Year June 16 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-16-95
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Signalman		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania R.R.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Tubman T. Beauchamp		14. MOTHER'S MAIDEN NAME Mary Long	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 717-07-5297	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 203x Bronchopneumonia, bilateral, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Plasma cell myeloma lumbar vertebra DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Arteriosclerosis, general, moderate - unknown		INTERVAL BETWEEN ONSET AND DEATH 72 to 96 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. s. p. m. Month, Day, Year VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 6, 19 57, to June 16, 19 57, that I saw the deceased alive on June 12, 19 57, and that death occurred at 7:15 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.	
DATE SIGNED 6-17-57			
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 6-17-57	
22c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery		22d. LOCATION (City, town, or county) (State) Perryman, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Perryville, Md.		24a. REC'D BY REGISTRAR DATE 6-17-57	
24b. REGISTRAR'S SIGNATURE Irene E. Langharty			

BUREAU V. S.

JUN 19 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06194

6196

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <i>USA Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton One day.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 North East</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		d. STREET ADDRESS <i>R.F. #1</i>	
3. NAME OF DECEASED (Type or print) <i>Newborn Baby - BENDER</i>		4. DATE OF DEATH Month <i>6</i> Day <i>18</i> Year <i>57</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-17-57</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <i>6</i> IF UNDER 1 YEAR Months <i>18</i> Days <i>19</i> IF UNDER 24 HRS. Hours <i>57</i> Min.
11. BIRTHPLACE (State or foreign country) <i>Elkton Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James A. Bender</i>		14. MOTHER'S MAIDEN NAME <i>Dorothy White</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>James A. Bender R.D. #1 North East Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Abortion (650.1) For Medical Reasons</i> <i>760.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Delivery Complicated by Antepartum Hemorrhage</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>5 1/2 mos Gestation - Preeclampsia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Clifton R. Brooks</i> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-21-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Bellevue Manor Memo Pk</i>		22d. LOCATION (City, town, or county) (State) <i>R.P. Elkton Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Henry Pappin</i> ADDRESS <i>Elkton Md.</i>		24a. REC'D BY REGISTRAR DATE <i>6/21/57</i>	
		24b. REGISTRAR'S SIGNATURE <i>H. J. Trager</i>	

2065242XVO

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		RECEIVED		RECEIVED		RECEIVED		RECEIVED	
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
OCCUPATION		PROFESSION		VOCATION		INDUSTRY		ART		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		OTHER		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
RELIGION		METHODIST		BAPTIST		CATHOLIC		OTHER		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
OCCUPATION		PROFESSION		VOCATION		INDUSTRY		ART		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		OTHER		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
RELIGION		METHODIST		BAPTIST		CATHOLIC		OTHER		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	

BUREAU V. 8

JUN 24 1957

RECEIVED

6213 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Haines</u> Last <u>Blackburn</u>				4. DATE OF DEATH Month <u>June</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5 1881</u>	9. AGE (In years last birthday) yrs. <u>75</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Cecil Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Blackburn</u>				14. MOTHER'S MAIDEN NAME <u>Mary Rebecca Ferguson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Louisa Blackburn Colora, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> (c) <u>General arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>3 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/12</u> , 19 <u>57</u> , to <u>6/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/14</u> , 19 <u>57</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u> DATE SIGNED <u>6/16/57</u> ACTUAL SIGNATURE <u>Neil Taylor</u> M.D. <u>Rising Sun, Md.</u> PHYSICIAN'S NAME (Type) <u>Neil Taylor</u> <u>Rising Sun, Md.</u> <u>6/16/57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 17 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>		22d. LOCATION (City, town, or county) (State) <u>Near Colora Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl Tyson, Rising Sun, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 18 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur</u>	

BUREAU V. S.

JUN 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6197

CERTIFICATE OF DEATH

06196

Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY Becil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hermitage Drive		d. STREET ADDRESS Hermitage Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Marie S. CAVVICO		4. DATE OF DEATH Month Day Year June 19 1957	
5. SEX F	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1877
9. AGE (In years lost birthday) yrs. 80		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY House Wife	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Wenzel Schuldtes		14. MOTHER'S MAIDEN NAME Catherine Wolf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Betty Minster		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosed Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 1954 to 6/19/57 , that I last saw the deceased alive on 6/18/57 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George J. Kreiss, Jr. M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Elkton, Md. 6/20/57	
PHYSICIAN'S NAME (Type) George J. Kreiss, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-21-1957	22c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery	22d. LOCATION (City, town, or county) (State) Elkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pippin		24a. REC'D BY REGISTRAR DATE 6/22/57	
ADDRESS Elkton, Md.		24b. REGISTRAR'S SIGNATURE H. H. Trager	

BUREAU V. S.

JUN 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06197

6198

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 24 Kent Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Salvador Crespedes				4. DATE OF DEATH Month Day Year 6 24 1957			
5. SEX M	6. COLOR OR RACE Wh.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1915		9. AGE (In years (last birthday) yrs. 41	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Assembly		10b. KIND OF BUSINESS OR INDUSTRY Chrysler Plant		11. BIRTHPLACE (State or foreign country) Spain		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Juan Cespedes Garcia				14. MOTHER'S MAIDEN NAME Juanita Garcia			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) W. W. # 2		16. SOCIAL SECURITY NO. 219-07-2377		17. INFORMANT 24 Kent Rd. Catherine Cespedes Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.5 Intestinal obstruction, small bowel DUE TO (b) Abdominal adhesions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH 13 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 577X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 6/11 1957, to 6/24 1957, that I last saw the deceased alive on 6/11 1957, and that death occurred at 8:12 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John A. Fischer, M.D.		ADDRESS (Street, city or town, state) 138 West Main St. Elkton, Maryland DATE SIGNED 6/24/57					
PHYSICIAN'S NAME (Type) John A. Fischer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-28-1957	22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS W. Henry Sippin Elkton Md.		24a. REC'D BY REGISTRAR DATE 6/27/57	24b. REGISTRAR'S SIGNATURE H. H. Frazier				

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		M		35		1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
Attorney		High School		Married		Catholic		White		White		5' 10"		175	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
June 4, 1968		London, England		Suicide		Voluntary		Gunshot wound		Bleeding from wound		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
JUN 28 1968
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6214

CERTIFICATE OF DEATH

06198

Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland - Cecil County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-North East	c. LENGTH OF STAY IN 1b All life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East-Rural L	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp-Elkton, Md		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ada Mrs Ada D. Collings		4. DATE OF DEATH Month June Day 13 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1880
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) North East, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Samuel Hoffman	
14. MOTHER'S MAIDEN NAME Mary Alexander		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Record	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio Vascular Renal Disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene of Rt. foot with amputation thigh May 10, 1957		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from May 3, 19 57 to June 13, 1957 , that I last saw the deceased alive on June 12, 1957 , and that death occurred at 4.10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) North East, Maryland DATE SIGNED June 14/57	
ACTUAL SIGNATURE <i>H. Arthur Centwall</i>	PHYSICIAN'S NAME (Type) H. Arthur Centwall, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-16-57	22c. NAME OF CEMETERY OR CREMATORY Methodist	22d. LOCATION (City, town, or county) (State) North East Md
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Shant</i>		24a. REC'D BY REGISTRAR DATE 6/16/57	24b. REGISTRAR'S SIGNATURE <i>JR. Trazar</i>

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Page 1000 10

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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BUREAU Y. A.

JUN 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6215

CERTIFICATE OF DEATH

06199

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen 12312	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First HOWARD Middle F. Last CULLUM		4. DATE OF DEATH Month 6 Day 16 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-26-92
9. AGE (In years last birthday) yrs. 65		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY General Contracting	
11. BIRTHPLACE (State or foreign country) Aberdeen, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert F. Cullum		14. MOTHER'S MAIDEN NAME Maggie Hamer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT VA HOSPITAL RECORDS, VAH, PERRY POINT, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Enteric Fistula 540.0 DUE TO Complicating Subtotal Gastric Resection For Bleeding Gastric Ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bleeding Gastric Ulcer DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Approx. 30 days Unk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 433.1 Cardiac Arrhythmia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. 19 Month, Day, Year VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-13 , 19 57 , to 6-16 , 19 57 , and that death occurred at 12:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE E. S. ELLS, MD M.D.			
PHYSICIAN'S NAME (Type) E. S. ELLS, M.D., Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-19-57	
22c. NAME OF CEMETERY OR CREMATORY Wesleyan Chapel		22d. LOCATION (City, town, or county) (State) Aberdeen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Herring		24a. REC'D BY REGISTRAR June 16, 1957	
ADDRESS Aberdeen, Maryland		24b. REGISTRAR'S SIGNATURE Irene E. Wang	

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		AGE [Illegible]		SEX [Illegible]		RACE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CITY [Illegible]		STATE [Illegible]	
OCCUPATION [Illegible]		EDUCATION [Illegible]		MARRIAGE [Illegible]		RELIGION [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF WITNESS [Illegible]	
DATE OF BURIAL [Illegible]		PLACE OF BURIAL [Illegible]		CITY [Illegible]		STATE [Illegible]	

BUREAU V. 2

JUN 18 1957

RECEIVED

Handwritten signature/initials

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06200

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 9 yrs. 1 mo.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4		d. STREET ADDRESS 400 West Saratoga	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle C. Last FISCHER		4. DATE OF DEATH Month June Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-11-92
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-07-116	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Bronchopneumonia, right lower lobe, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Encephalomalacia of frontal and temporal lobes, due to arteriosclerosis (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 4 - 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19, 1948, to June 19, 1957, that I last saw the deceased alive on June 19, 1957, and that death occurred at 12:45 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W. Oppler M.D. V.A. Hospital, Perry Point, Md. 6-20-57 PHYSICIAN'S NAME (Type) W. OPPLER Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL Removal		22b. DATE THEREOF 6-20-57	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE 6-21-57	
24b. REGISTRAR'S SIGNATURE Irene E. Dougherty			

BUREAU V. S.

JUN 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6199

CERTIFICATE OF DEATH

06201

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN 1b <u>X1 RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON RFD # 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>			d. STREET ADDRESS <u>ELKTON RFD # 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>John W. Fossett</u>			4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 29, 1898</u>	9. AGE (In years lost birthday) yrs. <u>58</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			13. FATHER'S NAME <u>JOHN T. FOSSETT</u>		
14. MOTHER'S MAIDEN NAME <u>ANNIE SCARBOROUGH</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Address <u>MRS. MAY FOSSETT ELKTON, MD. RFD # 3</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC Arrest</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Duodenal diverticulum 572.1</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			20g. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>6/2</u> , 19 <u>57</u> , to <u>6/3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/3</u> , 19 <u>57</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>John A. Fischer, M.D.</u>			ADDRESS (Street, city or town, state) <u>138 W MAIN ST. ELKTON, MARYLAND</u>		
DATE SIGNED <u>6/3/57</u>					
PHYSICIAN'S NAME (Type) <u>John A. Fischer</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 6, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEWARK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>NEWARK DEL.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. T. Jones</u>			ADDRESS <u>Newark, Delaware</u>		24a. REC'D BY REGISTRAR DATE <u>6/6/57</u>
24b. REGISTRAR'S SIGNATURE <u>J. P. Frazier</u>					

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 1

JUN 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6217

CERTIFICATE OF DEATH

Reg. Dist. No.

06202

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Philadelphia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia 75 X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN (NMI) GILL				4. DATE OF DEATH Month Day Year June 20 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-15-92	
9. AGE (In years lost birthday) yrs. 65		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, severe 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease, severe DUE TO (c) Peritonitis acute localized following prostatectomy 48 hrs.							INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0 Arteriosclerosis general, severe - unknown							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 25, 19 25, to June 20, 19 57, that I saw the deceased alive on 19 25, and that death occurred at 3:05 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oppler				ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 6-24-57			
PHYSICIAN'S NAME (Type) W. OPPLER				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-22-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son				ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 6-26-57	
				24b. REGISTRAR'S SIGNATURE Irene E. Dougherty			

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 27 1957

RECEIVED

6218

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Crisfield		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 18 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital			d. STREET ADDRESS Route #1		
3. NAME OF DECEASED (Type or print) First EDGAR Middle F. Last GRAY			4. DATE OF DEATH Month June Day 10 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-24-88		9. AGE (In years lost birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Pete Gray			14. MOTHER'S MAIDEN NAME Kate Riffin		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 217-01-4620	17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 593x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Renal disease, type undetermined DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. VA 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 23 , 19 57 , to June 10 , 19 57 , and that death occurred at 2:45 a.m. , from the causes and on the date stated above.					
ACTUAL SIGNATURE W. Oepeler		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 6-10-57			
PHYSICIAN'S NAME (Type) W. Oepeler		Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 6-10-57	22c. NAME OF CEMETERY OR CREMATORY unknown	22d. LOCATION (City, town, or county) (State) Crisfield, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw Funeral Home, Crisfield, Maryland		24a. REC'D BY REGISTRAR DATE 6-10-57	24b. REGISTRAR'S SIGNATURE Irene E. Daugherty		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

JUN 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6219

CERTIFICATE OF DEATH

06204

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Conowingo Md.</u>				c. LENGTH OF STAY IN 1b <u>40 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Rural-Conowingo x 2</u>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Graybeal</u> Last <u>Graybeal</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/8/1885</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>		IF UNDER 24 HRS. Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Carpenter</u>			
11. BIRTHPLACE (State or foreign country) <u>Ash Co. North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Winton Graybeal</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>314-185606</u>			
17. INFORMANT <u>Mrs. Myrtle Graybeal Conowingo Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pericardial Infarction</u> DUE TO <u>Anterior Scervix</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anterior Scervix</u> DUE TO <u>Anterior Scervix</u> (c) <u>Anterior Scervix</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. n.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 12, 1957</u> to <u>June 12, 1957</u> , that I last saw the deceased alive on <u>June 12, 1957</u> , and that death occurred at <u>5:00</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. P. Smith</u> M.D.				ADDRESS (Street, city or town, state) <u>Baltimore Md.</u>			
DATE SIGNED <u>June 12, 1957</u>							
PHYSICIAN'S NAME (Type) <u>A. P. Smith M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 13/57</u>		<u>West Nottingham</u>		<u>Colorado Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Earl Tyson, Rising Sun</u>				ADDRESS <u>Rising Sun</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 18 57</u>	
24b. REGISTRAR'S SIGNATURE <u>Al Smith</u>							

JUN 18 1957

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6220

CERTIFICATE OF DEATH

06205

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2801 Jopley Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First LOUIS Middle J. Last GROSS		4. DATE OF DEATH Month June Day 6 Year 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-31-14		9. AGE (In years lost, birthday) 43 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Gross				14. MOTHER'S MAIDEN NAME Maggie Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-07-1731		17. INFORMANT Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach with metastasis 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. ft. VA 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 31 , 19 57 , to June 6 , 19 57 , that I last saw the deceased alive on June 6 , 19 57 , and that death occurred at 4:31 p.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oppler		M.D. V.A. Hospital, Perry Point, Md.				DATE SIGNED 6-7-57	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-7-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bennington & Son				ADDRESS Hayre de Grace, Md.		24c. REC'D BY REGISTRAR DATE 6-7-57	
				24b. REGISTRAR'S SIGNATURE Irene E. Dougherty			

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6221

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06206

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton R.F.D. #4</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Cedar Hills, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>7</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Douglas W. G. Hammond</u>		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16, 1909</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u>47</u> Days <u>17</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Davis Hammond</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Irene Gale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W. 2</u>		16. SOCIAL SECURITY NO. <u>222-03-7387</u>	
17. INFORMANT <u>Anthony D. Hammond</u>		Address <u>Elkton RFD. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>929.8</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>7-15</u> Hour <u>6:00</u> p. m. <u>6-17 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Creek</u>		20f. (City or town) <u>Blueball</u> (County) <u>Beid</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. C. Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. C. Dodson</u> <u>D. M. E.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6-16-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 21, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Northeast Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Piggan</u>		ADDRESS <u>Elkton, Md.</u>	
24a. REC'D BY REGISTRAR <u>6/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>FRJ</u>	

RECEIVED

JUN 24 1957

BUREAU V. 3

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6200

CERTIFICATE OF DEATH

06207

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Cecil</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Cecil</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Belton</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit x 2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>			d. STREET ADDRESS <i>10 Race St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Sarah</i> Middle <i>Rebecca</i> Last <i>Hopkins</i>			4. DATE OF DEATH Month <i>June</i> Day <i>18</i> Year <i>1957</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-6-1889</i>	9. AGE (In years last birthday) <i>68</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>unknown</i>			14. MOTHER'S MAIDEN NAME <i>Carrie Jewe</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <i>Edna Bethards, Port Deposit, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c) <i>Hypertensive Cardiovascular Disease</i>					INTERVAL BETWEEN ONSET AND DEATH <i>12 yrs.</i> <i>6 yrs.</i> <i>6 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>331X</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <i>17 June</i> , 19 <i>57</i> , to <i>18 June</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>17 June</i> , 19 <i>57</i> , and that death occurred at <i>7:50 A.M.</i> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Klaus H. Huebner</i>		M.D. <i>North East, Md</i>		DATE SIGNED <i>18 June '57</i>	
PHYSICIAN'S NAME (Type) <i>Klaus H. Huebner M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>	<i>6-21-57</i>	<i>Mt Zoar</i>		<i>Conowingo, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leea. Patterson & Son, Perryville, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>6/21/57</i>	24b. REGISTRAR'S SIGNATURE <i>JR. Frazier</i>

JUN 24 1957

RECEIVED

6222

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Touch			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21032			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1233 Salem Avenue			
3. NAME OF DECEASED First JOHN Middle T. Last HYNES				4. DATE OF DEATH Month June Day 26 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-21-83		9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner				10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, left lower lobe 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease, severe DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema, bilateral, severe - unknown. Arteriosclerosis, general, severe							INTERVAL BETWEEN ONSET AND DEATH 4-5 days unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 491X							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 491X			20c. TIME OF INJURY Hour a. j. p. m. VA 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) VA			(County) (State)	
21. I certify that I attended the deceased from March 26 _____, 19 27 _____, to June 26 _____, 19 57 _____, and that death occurred at 6:55 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA DATE SIGNED 6-28-57							
ACTUAL SIGNATURE W. Opller				M.D. V.A. Hospital, Perry Point, Md.			
PHYSICIAN'S NAME (Type) W. OPLIER				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-27-57		22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Perminston & Son				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE 6-28-57	
24b. REGISTRAR'S SIGNATURE L. E. Montgomery							

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU V. 1

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		1912		NEW YORK	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1935		NEW YORK		JANE J. JONES		1978		NEW YORK	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
LABORER		1978		NEW YORK		JAMES J. JONES		1978		NEW YORK	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		1978		NEW YORK		JAMES J. JONES		1978		NEW YORK	
MANNER OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
NATURAL		1978		NEW YORK		JAMES J. JONES		1978		NEW YORK	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		1978		NEW YORK		JAMES J. JONES		1978		NEW YORK	
SIGNATURE OF REGISTRAR		DATE		PLACE		NAME OF REGISTRAR		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		1978		NEW YORK		JAMES J. JONES		1978		NEW YORK	

BUREAU V. 1

JUL 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6223

CERTIFICATE OF DEATH

06209

Reg. Dist. No. 93

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Street</u>				d. STREET ADDRESS <u>Washington, Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary L. Johnson</u>				4. DATE OF DEATH Month Day Year <u>June 29 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 6, 1879</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Cole</u>				14. MOTHER'S MAIDEN NAME <u>Emmaline-?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Lelia Landram-North East. Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Gangrene of left Foot</u> <u>450.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____		(County) (State)	
21. I certify that I attended the deceased from <u>1 March</u> , 19 <u>57</u> , to <u>29 June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>22 June</u> , 19 <u>57</u> , and that death occurred at <u>4:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Klaus H. Hubner</u>				ADDRESS (Street, city or town, state) <u>North East, Md.</u>		DATE SIGNED <u>29 June '57</u>	
PHYSICIAN'S NAME (Type) <u>Klaus H. Hubner M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Griffin Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cedar Hill, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Bell</u>				ADDRESS <u>909 Poplar St., Wilms.</u>		24a. REC'D BY REGISTRAR DATE <u>7/3/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>JR Drager</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF BIRTH [Faint text, possibly "1912"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		DATE OF DEATH [Faint text, possibly "July 5, 1957"]		PLACE OF DEATH [Faint text, possibly "Home"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "J. H. Smith"]	
SIGNATURE OF REGISTRAR [Faint text, possibly "A. B. Jones"]		SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "Jane Doe"]	

BUREAU V. 2

JUL 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6224

CERTIFICATE OF DEATH

Reg. Dist. No.

06210

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit, Md.</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah E. Krauss</u>				4. DATE OF DEATH Month Day Year <u>June 11 19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 20, 1883</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Abraham Hasson</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah Kelly</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Chester Krauss, Jr. Port Deposit, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thyocarditis -</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug 1954</u> to <u>June 11, 1957</u> , that I last saw the deceased alive on <u>June 11, 1957</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clarence J. Benson</u> M.D.				ADDRESS (Street, city or town, state) <u>Port Deposit, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Dr. C. I. Benson, Port Deposit, Maryland.</u>				DATE SIGNED <u>6/13/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 14, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit, RD. Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. A. Patterson & Son</u>				ADDRESS <u>Perryville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>June 14, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Irene E. Daugherty</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		YEAR	
CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT		DIAGNOSIS	
MANNER OF DEATH		Circumstances		Witnesses		Physician		Coroner	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased	
Date of Death		Time of Death		Place of Death		City		County	
State		Year		Month		Day		Hour	
Minute		Second		Tenth		Hundredth		Thousandth	
Signature of Registrar		Signature of Witness		Signature of Deceased		Signature of Physician		Signature of Coroner	
Date of Death		Time of Death		Place of Death		City		County	
State		Year		Month		Day		Hour	
Minute		Second		Tenth		Hundredth		Thousandth	

BUREAU V. B.

JUN 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

6201 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06211

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b All life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Elkton R.D. 2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Elkton Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William A Lair				4. DATE OF DEATH Month Day Year 6 3 19 57			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5 1869		9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Labor		10b. KIND OF BUSINESS OR INDUSTRY General Labor		11. BIRTHPLACE (State or foreign country) Cecil Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME R Benjamin Lair				14. MOTHER'S MAIDEN NAME Mary Jane Rittenhouse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Wm Lusby, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 900.0 Fracture base of Skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall down cellar steps 20c. TIME OF INJURY Month, Day, Year Hour 07 2:40 a.m. 5-31-57 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Elkton Cecil Md. 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE R.C. Dodson M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) R.C. Dodson ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6-3-57 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 6-5-57 22c. NAME OF CEMETERY OR CREMATORY Zion 22d. LOCATION (City, town, or county) (State) North East R.D. Md. 24a. REC'D BY REGISTRAR DATE 6/5/57 24b. REGISTRAR'S SIGNATURE H. J. Jager							

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5 NOV 1964

JUN 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled in by the attending physician. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06212

6225

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 15yrs.3mo.6days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Norfolk c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83x-3 d. STREET ADDRESS 1118 Rodgers e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle C. Last Langhorne		4. DATE OF DEATH Month June Day 18 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-?-93
9. AGE (In years lost birthday) 63 yrs.		IF UNDER 1 YEAR Months 6 Days 18	IF UNDER 24 HRS. Hours 19 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, unresolved, right lower lobe 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary heart disease, severe DUE TO (c) Tuberculosis, pulmonary, inactive (clinical)		INTERVAL BETWEEN ONSET AND DEATH 7-10 days unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X Arteriosclerosis, general, severe - unknown		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 12 , 19 42 , to June 18 , 19 57 , that I last saw the deceased alive on June 18, 1957 , and that death occurred at 10:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler PHYSICIAN'S NAME (Type) W. OPPLER		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 6-18-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 6-18-57	
22c. NAME OF CEMETERY OR CREMATORY Forest Lawn		22d. LOCATION (City, town, or county) Norfolk, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 6-19-57	
24b. REGISTRAR'S SIGNATURE Irene E. Dougherty			

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

6202

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06213

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 19 yrs in Co.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown X		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital D.O.A.				d. STREET ADDRESS 1					
3. NAME OF DECEASED (Type or print) Charles William Laramore				4. DATE OF DEATH Month 6- Day 25 Year 57					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-11-1894			
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Ret.		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Church Hill. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Wm. Laramore				14. MOTHER'S MAIDEN NAME Clough					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes.		16. SOCIAL SECURITY NO. (If not, give year or dates of service) W.W. I 221-10-2271		17. INFORMANT Address Charles Laramore, Charlestown. Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6-26-57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-29-1957		22c. NAME OF CEMETERY OR CREMATORY Charlestown Cemetery		22d. LOCATION (City, town, or county) (State) Charlestown Md			
23. FUNERAL DIRECTOR'S SIGNATURE Mr. Henry Pippin				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE 6/27/57			
						24b. REGISTRAR'S SIGNATURE J.H. Tague			

JUN 28 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6226

CERTIFICATE OF DEATH

06256

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 1 mo. 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1903-15th Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First FREDERICK		Middle (NMI)		Last LE COMTE	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-12-89	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH June 30 1957	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Window Washer		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel LeComte				14. MOTHER'S MAIDEN NAME Florida Dulaney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WW 1 578-12-1158		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Edema pulmonary acute due to Pancreatitis DUE TO hemorrhagic (cause unknown) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease severe DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 587.0 Arteriosclerosis general - unknown INTERVAL BETWEEN ONSET AND DEATH 2 - 3 hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 27, 1957, to June 30, 1957, that I saw the deceased alive on June 29, 1957, and that death occurred at 7:25 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W. C. Opler M.D. V.A. Hospital, Perry Point, Md. 7-2-57 PHYSICIAN'S NAME (Type) W. Opler Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-2-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Sons				ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 7-5-57 24b. REGISTRAR'S SIGNATURE Irene E. Longherty	

RECEIVED

JUL 8 1957

BUREAU V. 2

CERTIFICATE OF DEATH

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06214

6227

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 13 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital			e. STREET ADDRESS 1801 Warwick Avenue		
3. NAME OF DECEASED (Type or print) CHARLES J. MATHEWS			4. DATE OF DEATH Month June Day 3 Year 19 57		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-23-14	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook			10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Michigan
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Unknown		
14. MOTHER'S MAIDEN NAME Creasie (?) Barnes			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstruction of the intestines due to infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Infarction of the myocardium due to unknown cause DUE TO (c) Myocarditis of unknown cause					INTERVAL BETWEEN ONSET AND DEATH 7-10 days unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 540.0 Ulcers, gastric, multiple - Unknown					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May 21 , 19 57 , to June 3 , 19 57 , and that death occurred at 12:50 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE W. Oppier		M.D. V.A. Hospital, Perry Point, Md.		DATE SIGNED 6-5-57	
PHYSICIAN'S NAME (Type) W. OPIER		Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL Removal		22b. DATE THEREOF 6-5-57		22c. NAME OF CEMETERY OR CREMATORY Moss Grove	
22d. LOCATION (City, town, or county) Louisiana		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Inc.		ADDRESS Howe de Grace, Md.		24a. REC'D BY REGISTRAR DATE 6-6-57	
24b. REGISTRAR'S SIGNATURE J. E. Longfellow					

BUREAU V. S.

JUN 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6228

CERTIFICATE OF DEATH

Reg. Dist. No.

06215

96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Perryville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Katherine A. McVey		4. DATE OF DEATH Month Day Year June 17 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1858
9. AGE (In years last birthday) 98 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathan McVey		14. MOTHER'S MAIDEN NAME Elizabeth ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Harry W. Gallion, Perryville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Cerebral Sclerosis - DUE TO (b) Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months - 9 yrs -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1 Myocarditis -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10, 1957, to June 16, 1957, that I last saw the deceased alive on June 16, 1957, and that death occurred at 11:00 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence I. Benson M.D.		ADDRESS (Street, city or town, state) Port Deposit, Md. DATE SIGNED 6/19/57	
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/57	
22c. NAME OF CEMETERY OR CREMATORY Harmony Chapel		22d. LOCATION (City, town, or county) (State) Liberty Grove, Cecil, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son		ADDRESS Perryville, Maryland	
24a. REC'D BY REGISTRAR DATE 6-20-57		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6229

CERTIFICATE OF DEATH

Reg. Dist. No.

06216

97

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge				c. LENGTH OF STAY IN 1b 4 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 114 A Preston Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Andrew Middle (n) Last MILLER				4. DATE OF DEATH Month June Day 26 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-25-57		9. AGE (In years lost birthday) yrs. 4	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Earnest (n) Miller				14. MOTHER'S MAIDEN NAME Sarah J. Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. -----		17. INFORMANT Navy Records			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. -----		17. INFORMANT Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ERYTHROBLASTOSIS, Fetal (7700) 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 June , 19 57 , to 26 June , 19 57 , that I last saw the deceased alive on 26 June , 19 57 , and that death occurred at 1:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U. S. Naval Hospital 6-27-57							
ACTUAL SIGNATURE L. J. Bise		M.D. U. S. Naval Hospital					
PHYSICIAN'S NAME (Type) A. J. BISESE, LT MC USNR		Bainbridge, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-27-57		22c. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery		22d. LOCATION (City, town, or county) (State) Rural Port Deposit, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. A. Patterson & Son, Baltimore, Md.				ADDRESS 2051 288 XV4		24a. REC'D BY REGISTRAR DATE 6-27-57	
				24b. REGISTRAR'S SIGNATURE Norothy B. Brundell			

WESTLAND STATE CERTIFICATE OF DEATH
 1957

NAME OF DECEASED [Illegible]		DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]	
SEX [Illegible]		RACE [Illegible]		EDUCATION [Illegible]	
OCCUPATION [Illegible]		MARRIAGE [Illegible]		RELIGION [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		CERTIFICATE NO. [Illegible]		REGISTRATION NO. [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	

RECEIVED
 JUL 1 1957
 BUREAU V. 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06217

6203

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elk Mills X 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANDREW Middle F. Last MOORE				4. DATE OF DEATH Month June Day 30 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 31, 1881		9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weaver		10b. KIND OF BUSINESS OR INDUSTRY Textile Mfg.		11. BIRTHPLACE (State or foreign country) North East Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Moore				14. MOTHER'S MAIDEN NAME Rebecca Atkinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-09-8862		17. INFORMANT Alice R. Moore (Wife)		Address Elk Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular disease 422.1 DUE TO with congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 433.1						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from May 5 , 19 57 , to June 30 , 19 57 , that I last saw the deceased alive on June 30 , 19 57 , and that death occurred at 2:35 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		M.D. 233 East Main Street		ADDRESS (Street, city or town, state) Elkton, Maryland		DATE SIGNED 6/30/57	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		Elkton, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3, 1957		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cecil County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				ADDRESS Elkton, Maryland		24a. REC'D BY REGISTRAR DATE 7/1/57	
				24b. REGISTRAR'S SIGNATURE FR Frazier			

RECEIVED

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ORDINARY PT</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>PA</u> b. COUNTY <u>CHESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENNETT SQUARE</u> d. STREET ADDRESS <u>400 CENTER ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KERRY</u> Middle <u>PATRICK</u> Last <u>O'NEILL</u>		4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. BIRTH DATE OF BIRTH <u>DEC 20, 1948</u>
9. AGE (In years last birthday) <u>9</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>10</u> Hours <u>10</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STUDENT</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN H O'NEILL</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE CERRA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ALLEN C BARRWELL, KENNETT SQ</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNED</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>929.8</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stepped off Sand Bar in Sasapass River</u>	
20c. TIME OF INJURY Month, Day, Year <u>6 30 1957</u> Hour <u>2:30</u> a. m. <u>—</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sasapass River Ordinary Pt Cecil Md</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Pelle Dodson</u>		DATE SIGNED <u>7-3-57</u>	
EXAMINER'S NAME (Type) <u>PC Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried July 5, 1957 St. Patrick's</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State) <u>KENNETT SQUARE PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Culshaw Millington Md.</u>		24a. REC'D BY REGISTRAR	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Quel-ouch</u>	
DATE <u>JUL 8 '57</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10045 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11809

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Indiana</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>			c. LENGTH OF STAY IN 1b <u>11yrs5mos29days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blairsville</u> 75x-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>415 N. Spring St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>WILBUR</u> Middle <u>C</u> Last <u>POLLOCK</u>				4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1957</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 10, 1902</u>		
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>		11. BIRTHPLACE (State or foreign country) <u>Rochester, Penna.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Melvin Pollock</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Cochran</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW-II</u>		17. INFORMANT Address <u>Hospital Records, VAH., Perry Point, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heat Exhaustion</u> 931.7 DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour _____ o. m. _____ p. m. 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <u>R. C. DODSON</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-17-57</u>		
EXAMINER'S NAME (Type) <u>R. C. DODSON, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>11-17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		22d. LOCATION (City, town, or county) (State) <u>Blairsville, Penna.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington A. Son</u> ADDRESS <u>Harvey e Grace, Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Irene E. Dougherty</u>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BATTLE, 18
 1967 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		EDUCATION		OCCUPATION		MARRIAGE		RELIGION		SOCIETY		POLITICAL PARTY		MILITARY SERVICE		HONORARY SERVICE		OTHER SERVICE		REMARKS	
BATTLE, JAMES EARL		11-11-1928		M		W		H		H		H		H		H		H		H		H		H		H	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASES PREEXISTING		DISEASES ACQUIRED		DISEASES PRESENT		DISEASES PRESENT		DISEASES PRESENT		DISEASES PRESENT		DISEASES PRESENT		DISEASES PRESENT		DISEASES PRESENT	
ST. LOUIS, MO.		11-19-1967		10:00 PM		HEART DISEASE		NATURAL		HYPERTENSION		CORONARY ARTERY DISEASE		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION	
PLACE OF DEATH		DATE OF EXAMINATION		TIME OF EXAMINATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASES PREEXISTING		DISEASES ACQUIRED		DISEASES PRESENT		DISEASES PRESENT		DISEASES PRESENT		DISEASES PRESENT		DISEASES PRESENT		DISEASES PRESENT		DISEASES PRESENT	
ST. LOUIS, MO.		11-19-1967		10:00 PM		HEART DISEASE		NATURAL		HYPERTENSION		CORONARY ARTERY DISEASE		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION	
PLACE OF EXAMINATION		DATE OF EXAMINATION		TIME OF EXAMINATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASES PREEXISTING		DISEASES ACQUIRED		DISEASES PRESENT		DISEASES PRESENT		DISEASES PRESENT		DISEASES PRESENT		DISEASES PRESENT		DISEASES PRESENT		DISEASES PRESENT	
ST. LOUIS, MO.		11-19-1967		10:00 PM		HEART DISEASE		NATURAL		HYPERTENSION		CORONARY ARTERY DISEASE		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION		MYOCARDIAL INFARCTION	

RECEIVED
 NOV 19 1967
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06218

Item 9, Film G217, 6/21/57

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMORY Middle P. Last RECTOR		4. DATE OF DEATH Month June Day 13 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-86
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME T. P. Rector		14. MOTHER'S MAIDEN NAME Mary Ella (Rector) Bonham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Peace Time		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address HospitalRecords, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, uremic poisoning 757.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypoplasia at the right kidney (c) Absence of the left kidney acquired INTERVAL BETWEEN ONSET AND DEATH 7 days unknown 6-4-57			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.8 Arteriosclerosis, general, moderate - unknown			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 28, 1950, to June 13, 1957, and that death occurred at 1:02 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 6-14-57	
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 6-14-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Arlington Funeral Home, Arlington, Va.		24a. REC'D BY REGISTRAR DATE JUN 18 1957	
		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
John Doe		45		Male		White		1912		Maryland	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
123 Main St.		Teacher		Heart Disease		Natural		June 15, 1957		Home	
FATHER		MOTHER		SPOUSE		CHILDREN		PREVIOUS ILLNESS		HISTORY	
John Doe		Jane Doe		Mary Doe		John Doe		None		None	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
June 18, 1957		J. Smith		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JUN 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

6232

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06219

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton RDI		c. LENGTH OF STAY IN lb 2 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Elkton, R.D.1	
3. NAME OF DECEASED (Type or print) First Middle Last Elsie Ann Rice		4. DATE OF DEATH Month 6 Day 2 Year 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1908
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Keeping House Cecil Co. Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Hickman		14. MOTHER'S MAIDEN NAME Lula Barrow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT Address Walter Rice, Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X Carcinoma of Uterus DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6-3-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-4-1957	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) near Elkton Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Poffin		ADDRESS Elkton Md.	
24a. REC'D BY REGISTRAR DATE 6/5/57		24b. REGISTRAR'S SIGNATURE J.R. Jager	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3.

JUN 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6233

CERTIFICATE OF DEATH

Reg. Dist. No.

06220
76

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rowlandville</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rowlandville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Richard Ropka</u> First Middle Last				4. DATE OF DEATH Month <u>6</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 11, 1875</u>	9. AGE (In years last birthday) <u>81</u> yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscape Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert F. Ropka</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Lunther</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Eleanor P. Ropka, Rowlandville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Serobase Sclerosis -</u> <u>334x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-Sclerosis -</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 8, 1957</u> to <u>June 27, 1957</u> , that I last saw the deceased alive on <u>June 27 -</u> 1957, and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clarence I. Benson</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Port Deposit - June 29, 1957</u>			
PHYSICIAN'S NAME (Type) <u>CLARENCE I. BENSON</u>				<u>Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury</u>		22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Lee A. Patterson & Son, Perryville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>6-29-57</u>		24b. REGISTRAR'S SIGNATURE <u>Dwight E. Dougherty</u>	

NEW YORK STATE DEPARTMENT OF HEALTH—BUREAU OF VITAL RECORDS

2 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6234

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06221

Reg. Dist. No. 94

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Chester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coatsville 758-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Murphy Shore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Arthur Linton Sherill		4. DATE OF DEATH Month 6 Day 19 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-25-1943
9. AGE (In years last birthday) 13 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Coatsville, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Linton Sherill		14. MOTHER'S MAIDEN NAME Frances Harnish	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Arthur L. Sherill		Address 803 E. Main Coatsville, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was in river N. East and raft was floating a way.	
20c. TIME OF INJURY Month, Day, Year Hour, p. m. 6-19-57 12:22 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N. E. River		20f. (City or town) Charlestown Cecil Ma.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-22-1957	
22c. NAME OF CEMETERY OR CREMATORY Fairview		22d. LOCATION (City, town, or county) Coatsville Chester Co. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS NorthEast Md	
24a. REC'D BY REGISTRAR DATE 6-21-57		24b. REGISTRAR'S SIGNATURE Sarah E. Rothermel	

DATE SIGNED 6-20-57

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUN 24 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6204

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07368

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 14 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 123 Bells Lane				d. STREET ADDRESS 123 Bells Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Emma Smith				4. DATE OF DEATH Month Day Year 6 11 19 57			
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-24-1909		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY General House		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Smith				14. MOTHER'S MAIDEN NAME Mattie May Holland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mattie M. Thompson, 115 Bells Lane		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis and hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 447X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6-11-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/14/57		22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cem.		22d. LOCATION (City, town, or county) (State) Glasgow, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Bell				ADDRESS Wilmington		24a. REC'D BY REGISTRAR DATE 18 1957	
						24b. REGISTRAR'S SIGNATURE J. R. Hayes	

MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6205

CERTIFICATE OF DEATH

06222

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u> Cecil </u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u> Md </u> b. COUNTY <u> Cecil </u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u> Elkton </u>		c. LENGTH OF STAY IN 1b <u> 9 days </u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u> Port Deposit </u> x2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u> Union Hospital </u>			d. STREET ADDRESS <u> 111 N. Main St </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u> William </u> Middle <u> M. </u> Last <u> Smith </u>			4. DATE OF DEATH Month <u> June </u> Day <u> 2 </u> Year <u> 1957 </u>		
5. SEX <u> Male </u>	6. COLOR OR RACE <u> white </u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u> Sept. 5, 1882 </u>	9. AGE (In years last birthday) <u> 74 </u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> Laborer </u>		10b. KIND OF BUSINESS OR INDUSTRY <u> Way Laborer </u>		11. BIRTHPLACE (State or foreign country) <u> Md. </u>	
13. FATHER'S NAME <u> Charles L. Smith </u>			14. MOTHER'S MAIDEN NAME <u> Sarah We Moss </u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u> No. </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u> Mrs Charles E. Bridge, Port Deposit, Md </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u> Arteriosclerotic C-V Disease with congestive heart failure and auricular fibrillation </u> 422.1 - Due to - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u> unknown </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> Emphysema, malnutrition </u> 527.1					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u> May 24, 1957 </u> , to <u> June 2, 1957 </u> , that I last saw the deceased alive on <u> June 2, 1957 </u> , and that death occurred at <u> 11:20 AM </u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u> S. Ralph Andrews, Jr. </u>		ADDRESS (Street, city or town, state) <u> 233 E. Main Street </u>		DATE SIGNED <u> 6/2/57 </u>	
PHYSICIAN'S NAME (Type) <u> S. RALPH ANDREWS, JR., M.D. </u> <u> Elkton, Maryland </u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> Burial </u>	22b. DATE THEREOF <u> 6-4-1957 </u>	22c. NAME OF CEMETERY OR CREMATORY <u> Hopewell Cemetery </u>		22d. LOCATION (City, town, or county) (State) <u> Port Deposit Md. Rural </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u> Lee A. Patterson & Son, Perryville, Md. </u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u> 6/2/57 </u>		24b. REGISTRAR'S SIGNATURE <u> F. B. Frazer </u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL HISTORY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	

BUREAU V. 2

JUN 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06223

6235

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 5yrs.3mo.11days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83x-3 ✓		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1400 Ohio Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First GEORGE Middle E. Last SOPER		4. DATE OF DEATH		Month June Day 12 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-20-16		9. AGE (In years lost birthday) 40 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Service Station		11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Guy Soper				14. MOTHER'S MAIDEN NAME Alice Fridley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cellulitis of neck, massive, secondary to laryngectomy and radical neck operation for carcinoma 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)						INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. VA 19 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1 , 19 52 , to June 12 , 19 57 , and that death occurred at 11:10p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oppler		M.D. V.A. Hospital, Perry Point, Md.		DATE SIGNED 6-14-57			
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-14-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son				ADDRESS Harre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 6-14-57	
				24b. REGISTRAR'S SIGNATURE Isabel E. Dougherty			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6236

CERTIFICATE OF DEATH

Reg. Dist. No.

06224

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 4423 - 15th Street, N.W.	
3. NAME OF DECEASED (Type or print) First MIDDLE Last RICHARD SPENCER JR.		4. DATE OF DEATH Month Day Year June 12 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-31-82
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter - Retired		10b. KIND OF BUSINESS OR INDUSTRY Pullman	
11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Spencer		14. MOTHER'S MAIDEN NAME Ellen Mundy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. S.A.W. 708 12 4883	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X Uremia, uremic poisoning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Arteriosclerosis, general, severe - unknown		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19 VA		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 23, 1957, to June 12, 1957, that I saw the deceased alive on _____, 1957, and that death occurred at 5:45 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W. Oppler M.D. V.A. Hospital, Perry Point, Md. 6-13-57 PHYSICIAN'S NAME (Type) W. OPPLER Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-12-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 12-13-57 24b. REGISTRAR'S SIGNATURE Irene E. Daugherty	

CERTIFICATE OF DEATH

6238

MAINTAIN STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

JUN 17 1957

RECEIVED

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	
AGE		SEX		RACE	
35		MALE		WHITE	
BIRTH DATE		BIRTH PLACE		CITY OF ORIGIN	
JANUARY 5, 1933		MOBILE, ALABAMA		MOBILE, ALABAMA	
OCCUPATION		EDUCATION		MARRIAGE	
MEMBER OF CONGRESS		HIGH SCHOOL		MARRIED	
PREVIOUS OCCUPATIONS		PREVIOUS PLACES OF RESIDENCE		PREVIOUS CITIES OF ORIGIN	
MEMBER OF CONGRESS		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
HEART DISEASE		SUICIDE		MEMPHIS, TENNESSEE	
DATE OF BURIAL		PLACE OF BURIAL		CITY OF ORIGIN	
APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6237

CERTIFICATE OF DEATH

06225

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit				c. LENGTH OF STAY IN 1b Life					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Port Deposit				d. STREET ADDRESS Main Street					
d. NAME OF HOSPITAL (If not in hospital, give street address) Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED First Middle Last Robert Lewis Stebbing				4. DATE OF DEATH Month Day Year June 2 1957					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 14, 1868			
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY General Store					
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME George H. Stebbing				14. MOTHER'S MAIDEN NAME Margaret Whalen					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 218-34-2208		17. INFORMANT Address Alberta Barr, Port Deposit, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Arterio Sclerosis - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 8 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 177X Carcinoma of Prostate - 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Port Deposit				20g. (County) Md.		20h. (State) Md.			
21. I certify that I attended the deceased from Jan 2, 1956 to June 2, 1957, that I last saw the deceased alive on June 2, 1957, and that death occurred at 3:40 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Port Deposit, Md. DATE SIGNED 6/3/57									
ACTUAL SIGNATURE Clarence I. Benson, M.D.				PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		22d. LOCATION (City, town, or county) (State) Port Deposit, R.D., Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son				ADDRESS Box 188, Perryville, Md.		24a. REC'D BY REGISTRAR DATE June 6, 1957			
24b. REGISTRAR'S SIGNATURE James E. Dougherty									

CERTIFICATE OF DEATH

1957

BUREAU V. M.

JUN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6238

CERTIFICATE OF DEATH

Reg. Dist. No.

06226

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 30yrs.7mo.29days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS 417 - 7th Street		
3. NAME OF DECEASED (Type or print) First MORRIS Middle (NMI) Last STERMAN			4. DATE OF DEATH Month June Day 11 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1891	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Lewis Sterman - Deceased		
14. MOTHER'S MAIDEN NAME Ida Tarshes - Deceased			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, following operation, 204.0 DUE TO Partial Colectomy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arteriosclerosis, severe DUE TO (c) Chronic lymphatic leukemia					INTERVAL BETWEEN ONSET AND DEATH 3-5 days unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1 Arteriosclerosis general severe - unknown					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA	
20f. (City or town) VA		(County) VA		(State) VA	
21. I certify that I attended the deceased from October 13, 1926 , to June 11, 1957 , and that death occurred at 3:10a M, from the causes and on the date stated above.					
ACTUAL SIGNATURE W. Oppler		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.			
PHYSICIAN'S NAME (Type) W. OPPLER		DATE SIGNED 6-12-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-12-57		22c. NAME OF CEMETERY OR CREMATORY Unknown	
22d. LOCATION (City, town, or county) Philipsburg, Pa.		(State) Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE June 13/57	
24b. REGISTRAR'S SIGNATURE June E. Wang					

RECEIVED

6239

CERTIFICATE OF DEATH

Reg. Dist. No.

06227
93

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CALVERT MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EIKTON (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital/give street address) OR INSTITUTION <u>Greybeal Nursing Home</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>TR</u> Middle <u>Stewart</u> Last		4. DATE OF DEATH <u>June 13</u> Month <u>13</u> Day <u>1957</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12 1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Tender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>450.0</u>	
17. INFORMANT <u>LAWRENCE F Stewart, Bristol PA</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> DUE TO <u>Cerebrovascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>arteriosclerosis</u> (b) <u>arteriosclerosis</u> (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 days</u> <u>10 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/25</u> , 19 <u>57</u> , to <u>6/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/12</u> , 19 <u>57</u> , and that death occurred at <u>6:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor Jr</u> M.D.		DATE SIGNED <u>6/16/57</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr</u>		ADDRESS (Street, city or town, state) <u>Rosebank</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-17-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rosebank</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert Cecil County</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R GRANT</u>		ADDRESS <u>North East, Md</u>	
24a. REC'D BY REGISTRAR <u>June 18 57</u>		24b. REGISTRAR'S SIGNATURE <u>Quincy</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5538

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1912		New York		New York		Heart Disease		June 15, 1957		10:00 AM		New York		John Doe, M.D.		John Doe, M.D.	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Last Seen Alive		Buried or Not		Burial Place		Burial Date		Burial Time		Burial Place		Signature of Minister		Signature of Registrar	
Teacher		Married		None		June 10, 1957		June 10, 1957		Buried		New York		June 15, 1957		10:00 AM		New York		John Doe, M.D.		John Doe, M.D.	

BUREAU V. 8

JUN 18 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06228

6206

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN 1b <u>5 WKS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION Hospital</u>		e. STREET ADDRESS <u>RD #1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMETT FRANKLIN STURGILL</u>		4. DATE OF DEATH Month Day Year <u>June 21 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Steve Sturgill</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA PERKINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>245-14-0424</u>	
17. INFORMANT Address <u>James Sturgill ELKTON RD1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage with hemiplegia</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 19</u> , 19 <u>57</u> , to <u>June 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 21</u> , 19 <u>57</u> , and that death occurred at <u>5:45 p. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u> M.D. <u>233 East Main Street</u>		<u>6/21/57</u>	
PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>		<u>Elkton Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GILPIN MANOR MEM. PARK</u>		22d. LOCATION (City, town, or county) (State) <u>CECIL Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter duBois, Jr.</u> ADDRESS <u>ELKTON, MD</u>		24a. REC'D BY REGISTRAR DATE <u>6/26/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>H. J. Trager</u>	

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6207

CERTIFICATE OF DEATH

07373

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <u>ecil</u> <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ecil</u>				c. LENGTH OF STAY IN 1b <u>x2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ecil neck</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union</u>				d. STREET ADDRESS <u>none</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Wall</u>				4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/24/67</u>	
9. AGE (In years last birthday) yrs. <u>3</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>ecil</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Angela R. Wall</u>		14. MOTHER'S MAIDEN NAME <u>Maurin Lloyd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Maurin Wall</u>		Address <u>ecil neck, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>751X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <u>Congenital Anomaly</u> (c) <u>(Meningocele)</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Clifton R. Brink</u> M.D.				PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/12/57</u>		<u>Bellin Memorial Church</u>		<u>Bellin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Revergent / Am Howard Shaw</u>				24a. REC'D BY REGISTRAR DATE <u>7-12-57</u>		24b. REGISTRAR'S SIGNATURE <u>Inone E. Dougherty</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6240

CERTIFICATE OF DEATH

06229

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 3 mos. 25 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 3144 Q St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First FRANK Middle WALLING Last WALLING			4. DATE OF DEATH Month June Day 7 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-9-1889	9. AGE (In years lost birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME William J. Walling			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. Unknown		
17. INFORMANT Hospital Records, VAH, Perry Point, Md.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) due to Atherosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331x					
INTERVAL BETWEEN ONSET AND DEATH 24 hours Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Feb. 12 , 19 57 , to June 7 , 19 57 , and that death occurred at 11:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. V. A. Hospital, Perry Point, Md. DATE SIGNED 6-9-57					
ACTUAL SIGNATURE W. Oppler M.D. V. A. Hospital, Perry Point, Md. 6-9-57					
PHYSICIAN'S NAME (Type) W. OPPLER Director Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-9-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county)		22e. (State)		22f. (Country)	
23. FUNERAL DIRECTOR'S SIGNATURE Benjamin J. Jones		ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 6-9-57	
24b. REGISTRAR'S SIGNATURE Frederic E. Dougherty					

CERTIFICATE OF DEATH

BUREAU V. 2

JUN 11 1957

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6208

CERTIFICATE OF DEATH

Reg. Dist. No.

06230

1. PLACE OF DEATH a. COUNTY CECIL ELKTON, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 15 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 355 W. Main St				e. STREET ADDRESS 355 West Main Street			
3. NAME OF DECEASED (Type or print) First OLGA Middle WIDDOES Last WIDDOES				4. DATE OF DEATH Month June Day 17 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 24, 1893	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 17 Days 19 Hours 57 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY House Work	
11. BIRTHPLACE (State or foreign country) Konesha, Wisconsin				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Roy Olsen				14. MOTHER'S MAIDEN NAME No information			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Thomas M. Widdoes Address 355 W. Main St. Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart disease DUE TO 0 (c) 0							INTERVAL BETWEEN ONSET AND DEATH 72 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 1953 to June 17 , 1957, that I last saw the deceased alive on June 16 , 1957, and that death occurred at 10:15 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Rayford H. Sprecher M.D.				ADDRESS (Street, city or town, state) 135 W. Main, Elkton, Md.			
DATE SIGNED June 18, 1957							
PHYSICIAN'S NAME (Type) Rayford H. Sprecher							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-20-1957		22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memo Pk.		22d. LOCATION (City, town, or county) (State) R. D. Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE M. Henry Pippin				ADDRESS Elkton Md.		24a. REC'D BY REGISTRAR DATE 6/21/57	
				24b. REGISTRAR'S SIGNATURE J. H. Frazier			

CERTIFICATE OF DEATH

1957

BUREAU V. S.

JUN 24 1957

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